Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
J. Thomas Dilger, Jr, MD

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-14-1020-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 12/3/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 12/9/12."

Amount in Dispute: $800.00 + 395 days of interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is processing for proper payment."

Response Submitted by: Galloway, Johnson, Tompkins, Burr and Smith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2012	Designated Doctor Examination	$800.00 + interest for 395 days	$25.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.130 sets outs the procedures for calculating interest for late payment on medical bills.
3. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
5. 28 Texas Administrative Code §102.4 sets out the procedures for non-commission communications.
6. Texas Labor Code §413.019 sets out the procedures for interest earned for delayed payments.
7. Texas Labor Code §401.023 sets out the procedures for determining the interest rate for workers' compensation payments.

8. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.

Issues

1. What is the correct MAR for the disputed services?
2. What is the interest for the disputed services per 28 Texas Administrative Code §134.130?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (-b-) $150 for each additional musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the left ring finger, left wrist, and right knee to find the Impairment Rating. Therefore, the correct MAR for this examination is $450.00.
2. The requestor alleges that interest is due for the service in dispute. 28 Texas Administrative Code §102.4 (p) states, "For purposes of determining the date of receipt for non-commission written communications, **unless the great weight of evidence indicates otherwise**, the Commission shall deem the received date to be five days after the date mailed via United States Postal Service regular mail; or the date faxed or electronically transmitted" [emphasis added]. Documentation supplied by the requestor supports that the medical bill was received on December 9, 2012.

   Pursuant to 28 Texas Administrative Code §134.130 (a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.240 of this title (relating to Medical Payment and Denials). Additionally, 28 Texas Administrative Code §134.130 (c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor code §401.023 and in effect on the date the payment was made."

   28 Texas Administrative Code §134.130 (d) defines how interest is calculated. The interest rate for the date of payment for the disputed services is 3.63%. Review of the submitted documentation finds that payment for the disputed services was made on December 18, 2013. Therefore, 313 days of interest on the disputed services is $25.04.
3. Review of the submitted documentation finds that the requestor is seeking reimbursement of $800.00 + 395 days of interest. The insurance carrier submitted payment of $800.00 for the disputed services and $0.00 interest. Therefore, an additional reimbursement of $25.04 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $25.04 per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 19, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.